MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Application for Food Stamps, TANF, PaS, or MaineCare

If your primary language is other than English, please list:

You only need to answer questions that concern the program(s) for which you are applying.

For Food Stamps, to immediately file this application we must have your name, address, and signature (or that of an authorized representative). If eligible, your benefits will begin from date of application.

Your Name (First, Middle, Last)	Maiden	Social Security #	Birthdate-(Mo/Day/Yr)

Mailing Address: Street, PO Box, RR or RFD (Include apartment number, care of, etc.)	Safe Delivery Address? No □ Yes □

City	State	Zip Code	Telephone/Message Number

Street, address and town where you actually live, if different

Have you or anyone in your household ever received Food Stamps, TANF or PaS and/or MaineCare? No □ Yes □
Who: Where: When:

Is this person fleeing to avoid prosecution or confinement for a felony or violation of probation or parole?
Who? Where? When? No □ Yes □

Is anyone 65 years or older? ⟶ No □ Yes □
Is anyone disabled? ⟶ No □ Yes □
Name(s): _____
Is anyone blind? ⟶ No □ Yes □
Name(s): _____
Is either parent unemployed? ⟶ No □ Yes □

Does anyone receive SSI? ⟶ No □ Yes □
Did anyone ever receive SSI? ⟶ No □ Yes □
Name(s): _____
Is anyone pregnant? ⟶ No □ Yes □
Name(s): _____
Due Date(s): _____

If your household has little or no income, you may be able to receive Food Stamps within a few days. If so, answer the following questions, complete and sign this application form.

How many people, including yourself, live in your home and purchase and prepare meals with you? _____
How much is your rent or mortgage? ⟶ $ _____
How much are your utilities? ⟶ $ _____
Do you pay separately for heat? ⟶ No □ Yes □
Has anyone received HEAP Fuel Assistance at your current residence since last October? ⟶ No □ Yes □
Are everyone you are applying for homeless and without free shelter? ⟶ No □ Yes □

Did all of the household income stop recently? ⟶ No □ Yes □
What is the total income you expect your household to receive this month? ⟶ $_____
How much do the members of your household have in cash or savings? ⟶ $_____
Is anyone in your household a migrant or seasonal farm worker? ⟶ No □ Yes □

I understand and agree to provide documents to prove what I have stated. **I understand and agree that the information I have given may be verified by federal, state and local officials or other persons and organizations. If I have given incorrect information, my application may be denied and I may be charged with giving false information.** I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules in the penalty warning. **I certify under penalty of perjury that my answers, including those concerning citizenship or alien status, are correct and complete for all persons applying for benefits.**

_____ _____ _____ _____
Applicant's Signature Date Interviewer Date

Please list if you have a Guardian, Conservator or Authorized Representative or someone who knows your financial situation whom you would like us to contact to help us determine if you are eligible:
Name: _____ Address: _____
Telephone Number: _____ _____

Expedite: No □ Yes □ Worker: _____ I.D. Verification: _____ Residence Verification: _____

Date received: _____ Date logged on: _____ 45th day: _____

Check what you want for each person.				Questions on this application apply to members of your household. This includes you, your spouse, and everyone else for whom you are requesting assistance. Please print answers.
Food Stamps	TANF	PaS	MaineCare	**Verification of information may be required.**

For Food Stamps: if eligible, you will receive reporting requirements. To receive a credit for some expenses, such as child support paid, medical expenses (for elderly or disabled members) or fuel assistance (HEAP), you may be asked for verification. Failure to report or verify such expenses at application or review (or at other times you need to report) may mean you will receive less Food Stamp benefits each month. This will be seen as your statement that your household does not want to receive credit for the unreported or unverified expense.

Last Name / Maiden Name	First Name	MI	Jr./Sr.	Social Security Number	Birthdate Mo/Da/Yr	Age	Sex M/F	Relation to you
APPLICANT PERSON ALREADY LISTED ON PAGE ONE								SELF

Please list place of birth for each person for whom you are requesting assistance.

First Name	Place of birth	First Name	Place of birth	First Name	Place of birth

Please complete a section for each adult applying for benefits. This information is voluntary. Your benefits will not be affected if you do not answer.	Applicant	Second Adult
Are you an American Indian or Alaskan Native? Circle the tribe you belong to: 1. Houlton Maliseet 2. Peter Dana Pt. Passamaquoddy 3. Pleasant Point Passamaquoddy 4. Penobscot 5. Aroostook Micmac 6. Other	No ☐ Yes ☐	No ☐ Yes ☐
Do you live on your tribe's reservation?	No ☐ Yes ☐	No ☐ Yes ☐

Please list anyone else who lives with you for whom you are not requesting assistance.

Name	Birthdate Mo/Da/Yr	Sex M/F	Relation to you	Amount paid to you (if applicable)	How often Paid?

List your shelter expenses. Do not include past due payments and Security Deposits.

	How Much	How Often		How Much	How Often		How Much	How Often
Rent			Lot Rent			Cooking Fuel		
Heat			Mortgage			Water		
Electricity			Property Taxes			Sewer		
Telephone (basic)			House Insurance			Trash Collection		

Is your heating cost included in your rent? → No ☐ Yes ☐

Has anyone received HEAP Fuel Assistance at your current residence? ⟶ No ☐ Yes ☐

Do you live in public housing? ⟶ No ☐ Yes ☐

Do you receive a rent subsidy? ⟶ No ☐ Yes ☐

How much? _____ How Often? _____

Has General Assistance helped you with any of these expenses in the last 6 months? ⟶ No ☐ Yes ☐

Does your mortgage include taxes and house insurance? ⟶ No ☐ Yes ☐

Does anyone outside your household pay all or part of these bills? ⟶ No ☐ Yes ☐

If yes, who? _____

Single
Married
Separated
Divorced
Widowed

Use one or more of the following codes. Your benefits will not be affected if you do not answer. For Ethnicity: P-Hispanic/Latino or blank for none. For Race: W-White, B-Black or African American, O-Asian, I-American Indian or Alaskan Native, H-Native Hawaiian or other Pacific Islander

1. Social Security
2. SSI
3. Veteran's Benefit (include claim #)
4. Unemployment Benefits
5. Child Support, Alimony
6. Railroad Retirement
7. Workers' Compensation
8. Military Allotment
9. Rental Property
10. Pension
11. Dividend, Interest Annuity
12. Grants, Loans, Scholarships
13. Any other income

Marital Status	U.S. Citizen Y/N, If N See below	Ethnicity P or Blank	Race Code	Highest school Grade/ Degree	Does person attend school at least half-time N/Y	Name of School	Served In Military? N/Y	Type of Unearned Income	Gross Amount	How often received

If not a US Citizen

	INS Status	Verified by
1.		
2.		
3.		
4.		
5.		
6.		

If served in military, answer following questions for each individual:

Name: _____
In which branch of the military did you serve? _____
When did you serve? (dates) _____to_____
Did you serve on foreign soil? Yes _____ No _____
Are you receiving VA benefits that include payment of prescription drugs? Yes _____ No _____ If yes, refer to VA 1-800-827-1000

Name: _____
In which branch of the military did you serve? _____
When did you serve? (dates) _____to_____
Did you serve on foreign soil? Yes _____ No _____
Are you receiving VA benefits that include payment of prescription drugs? Yes _____ No _____ If yes, refer to VA 1-800-827-1000

Are any of the above foster children, in state custody or boarders? ⟶ No □ Yes □ , If yes, who

_____ _____ _____

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political belief, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326 – W, Whitten Building, 1400 Independence Avenue, S. W. Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Earnings (including children). **<u>You must provide verification of all gross wages</u>: Last 4 weeks' wage stubs for TANF or PaS, Food Stamps and MaineCare.**

Has anyone quit a job in the last 60 days? No □ Yes □ If yes, who? _____
Is anyone on strike? No □ Yes □ If yes, who? _____
If between 18 – 49 years old, has anyone been told they are not eligible because of ABAWD rules?
No □ Yes □ If yes, who? _____

Is this person currently employed N/Y	If no, date last worked	Current or Last Employer's Name and Address	Type of work	# of hours worked weekly	Hourly rate of pay	Gross pay before deductions	How often is pay received	Weekday pay is received

Do you receive an Earned Income Tax Credit (EITC) in your normal paycheck? ⟶ No □ Yes □
Do you receive a yearly EITC? ⟶ No □ Yes □
If yes, how much $_____ When did you get your refund? _____
Does anyone give any money or assistance which is not listed to anyone in your household? ⟶ No □ Yes □
Does anyone pay child support? No Yes Who pays? _____
How much?_____ per _____ To whom? _____ For whom? _____
Do you expect any change in income or expenses? ⟶ No □ Yes □

Complete this section if <u>self-employed</u>. You must provide the most recent tax return or business records.

Name of person who is self-employed: _____ Is this a partnership or corporation? No □ Yes □
Name of Business: _____ Type of Business: _____ # hours worked weekly: _____
Gross Amount _____ How often? _____

If you are paying someone to take care of your children or disabled adults, complete the following.

Name of person being paid_____
Address_____
_____Phone #_____
How much help do you get with
child care expenses $_____ How often_____
Amount paid $ _____ How often _____
For whom: _____ Type of Provider:_____

Name of person being paid_____
Address_____
_____Phone #_____
How much help do you get with
child care expenses $_____ How often_____
Amount paid $ _____ How often _____
For whom: _____ Type of Provider: _____

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Licensed, Family Based (Relative or Non-Relative)
Licensed, Day Care Center (Relative or Non-Relative)
Unlicensed, In-home, Non-Relative
Unlicensed, In-home, Relative
Unlicensed, Family, Non-Relative
Unlicensed, Family, Relative
} Enter type on ACES

ASSETS

1. Cash Not in Bank
2. Savings Account
3. Checking Account
4. Credit Union Shares
5. Trust Accounts
6. Christmas Clubs
7. Life Insurance
8. Certificate of Deposit
9. Separate Identifiable
10. Stocks, Bonds, Annuities, Profit Sharing
11. IRA, 401K, Keogh Accounts
12. Prepaid Burial
13. Family Development Accounts

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Type of Asset See Above	Name of Bank/Institution	Account Number	Current Balance or Value
	_ _ _ _ _ _ _ _ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _ _ _ _	_ _ _ _ _ _ _ _

TANF/PaS Families Total Countable Cash Assets
$_____

Does anyone's name jointly appear on any Bank Accounts, Savings Accounts, Checking Accounts, Credit Union Accounts, Stocks, Bonds, Money Market Certificates or any type of property **other than those listed above**? No □ Yes □
Explain:

Does anyone have any land, buildings, or time shares, including jointly held real estate other than where you live? No □ Yes □
Explain:

Did anyone sell, trade, or give away anything of value during the last three months? No □ Yes □
Explain:

Has anyone recently received, or does anyone expect to receive in the near future, any payments such as retroactive government benefits, compensation, pay raises, lawsuit settlements, inheritance, etc.? No □ Yes □
Explain:

Does anyone have, or jointly own, any cars, trucks, boats, campers, motorcycles, snowmobiles, ATVs, trailers, skidders, tractors, or other motorized vehicles? If yes, list below: No □ Yes □

Year	Make/Model	Name(s) of Owner(s)	Amount Owed	Use	Exempt?	If Yes, Worker Justification
					No □ Yes □	
					No □ Yes □	
					No □ Yes □	

TURN OVER AND ANSWER QUESTIONS ON PAGE 6 ⟶

PARTIALLY EXEMPT FS	NON-EXEMPT LICENSED FS		TANF or PaS/MAINECARE AND UNLICENSED FS	
Value_____	Value_____	Value_____	Equity_____	Value_____
- Excluded Amt._____	-Excluded Amt._____	-Amt. Owed	-Excluded Amt._____	-Amt. Owed_____
= Net Assets_____	=Countable Value_____	=Equity_____	=Net FS Asset_____	=Net Assets_____
	Net Asset _____(greater of two amounts)			

Total Assets: FS _____ TANF/PaS _____ MaineCare _____

For All Programs

Does any child under 21 have a mother or father who is not living with you or who is deceased? No □ Yes □ If you answered YES, list the following information: ⟶	#1 - Name of Absent Parent and last known address		#2 - Name of Absent Parent and last known address	
	Name of child(ren)		Name of child(ren)	
Do you provide the primary home for this child?	No □ Yes □		No □ Yes □	
Do you usually provide the day-to-day care and make decisions concerning this child?	No □ Yes □		No □ Yes □	
Does this child sometimes live with the other parent?	No □ Yes □ How often?		No □ Yes □ How often?	
Do you share custody of this child?	No □ Yes □		No □ Yes □	
Does the other parent provide a home, physical care and guidance for this child in any way?	No □ Yes □ How?		No □ Yes □ How?	

If you are applying for TANF or PaS, are under age 18 and a parent or pregnant, please read this: Maine law prevents TANF or PaS cash benefits to never married minor parents. Instead of cash payments, the Department will send portions of the TANF or PaS benefit directly to vendors to pay monthly expenses. The rest of the TANF or PaS benefit must be sent to an adult payee who agrees to manage the money and agrees to explain how it is used on the minor's behalf. List the Name, Relationship, Address and Telephone # of the payee you would like the Department to consider:_____

If you are applying for TANF or PaS or MaineCare, answer the following questions.

Are you requesting help for any medical bills incurred within the **LAST THREE MONTHS**? No □ Yes □
Which months?

You must provide the medical bills or copies of them.

Does anyone pay for Medical Insurance? ⟶ No □ Yes □
Premium $ How often paid?

Has any child lost health insurance in the past 3 months? ⟶ No □ Yes □
If yes, why?

Is any child claimed as a tax dependent by someone other than his/her parent? ⟶ No □ Yes□

If you are applying for Food Stamps for elderly or disabled persons, answer the following questions.

This section applies to anyone who is age 60 or older OR who is receiving any type of total disability benefits. Do you pay over $35/month for medical insurance (including Medicare), over-the-counter or doctor-ordered medicines, dental care, hearing aids, eye care, transportation or any other medical service or supplies? No □ Yes □
List the anticipated expenses (and due dates of payments) and provide proof of expenses for the past year:

_____

_____

Please list anyone who has a red, white and blue Medicare card.	Name	Medicare Number (Voluntary For Non-Applicant)